retina and the cortex. The problems and responsibilities arising from this established fact are so great that, by comparison, the matter of vision screening in older children (8 October, p 958) is trivial. Certainly refractive errors appear in older children so long as body growth continues. Almost all of the 7.4% of children with later developing significant visual defect, found by Drs Peckham and Tibbenham, are myopes whose near vision is normal and whose distance vision will always remain correctable to normal even if undetected until adult life.

I do not think that sufficient emphasis has been placed, in this correspondence, on the one essential point: by 8 years plasticity in visual development is lost and eyes that have never learned to see centrally remain blind to discriminating vision.

R M YOUNGSON

British Military Hospital,
Hong Kong

* * * This correspondence is now closed.—Ed, *BMJ*.

Hospital appointment procedure

SIR,—May I be allowed a brief general riposte to the sharp responses to my letter (3 September, p 645)? All your correspondents work in hospitals and see things, understandably, solely from the hospital viewpoint. I was not surprised to have raised their hackles in drawing attention to a clumsy hospital procedure which undoubtedly lends itself to abuse.

In general practice—when it runs well and the hospital co-operates—if the GP considers a consultant opinion necessary his secretary can immediately type the referral letter. She then telephones the hospital, indicating the degree of urgency. (An estimation best made, surely, by a doctor who has examined the patient outside, rather than by one who has examined a piece of paper inside a hospital.) The date and time of the appointment are typed on the envelope and the letter given to the patient. This arrangement is immensely appreciated by the patient, who is spared anxiety and suspense, and by the GP, who knows what is happening to his patient. Time is saved; so is the cost of postage.

It is a bit tough that, whereas constant criticism of the GP from inside and outside the profession is a currently acceptable pastime, criticism by him is castigated as rocking the boat. My letter was not directed at the Middlesex Hospital, which provides an admirable district hospital service.

BENJAMIN LEE

London WC2

Obstetric audit in general practice

SIR,—Dr G N Marsh's audit of the pregnancies in his practice (15 October, p 1004) and his sensible plea for GP obstetricians to be given more realistic consideration in the planning and execution of future maternity services caused me to have a sad feeling of déjà vu. A similar review of the pregnancies in my previous practice, in Ayrshire, between 1958 and 1960¹ had almost identical results and conclusions.

Now, almost twenty years later, the trend towards more and more specialist hospital

confinements, often with obstetrical interference, is gaining pace. If the reason for this is that the drop in the birth rate necessitates a high specialist hospital confinement rate for teaching and training purposes, then this should be stated. If not, then is it not time that the argument that it is always safer to have a baby in a specialist hospital be refuted and the place of the GP obstetrician be reassessed?

Most GP vocational training schemes now include a six-month period of training in obstetrics. Is it right to allow the obstetrical skills of these young general practitioners to atrophy, by depriving them of the opportunity of looking after carefully selected patients in childbirth? Dr Marsh thinks no; and I would agree with him.

J S K STEVENSON

Department of General Practice,
Edinburgh

¹ Stevenson, J S K, *British Medical Journal*, 1961, **1**, 1673.

SIR,—The report by Dr G N Marsh (15 October, p 1004) on the experience of a GP maternity unit was interesting, but I cannot agree with his implied conclusion that perinatal mortality is lower in a GP maternity than in a consultant unit when patient selection has been taken into account. The number of deliveries was too small and the survey not designed in such a way that one can draw such conclusions.

When will someone answer this question by designing a prospective controlled trial in which women assessed as suitable for confinement in a GP unit are randomly allocated to either consultant unit or GP unit care?

R M DARLING

Harrogate, Yorks

Oestrogen:creatinine ratio in all pregnancies?

SIR,—We were interested in the recent article by Dr L G S Rao (1 October, p 874) on the value of measuring the urinary oestrogen:creatinine ratio (OCR) in pregnancy. He advocates extending the test to every patient rather than confining it to those thought by the obstetricians to be at special risk. Using the data in this paper, we have drawn up a table to show the incidence of fetal and perinatal mortality for those patients monitored for fetoplacental function compared with those in whom the OCR was not measured.

	No	Mortality (%)	
		Fetal	Perinatal
OCR monitored ..	5429	1.25	1.90
OCR not monitored ..	10 179	0.96	2.15

With the χ^2 test the difference between the groups for either mortality classification did not reach statistical significance ($P > 0.05$). This implies that the selection of patients for OCR determinations is ineffective. One must conclude that either new selection criteria are required or that all patients need to be monitored. We believe this finding is crucial to the argument for widening the scope of the OCR test, but before facing the technical and staffing problems of extending the laboratory service it is necessary to know whether the above results were biased in any way.

We therefore wish to ask Dr Rao on what basis patients were selected in his study both for OCR monitoring and for exclusion from measurement. In contrast to Dr Rao we are concerned about coping with the increased work load.

A T HOWARTH
P RISDON
DAVID P SMITH

Biochemistry Department,
Royal Infirmary,
Bradford

* * * We sent a copy of this letter to Dr Rao, whose reply is printed below.—Ed, *BMJ*.

SIR,—In reply to Dr Howarth and his colleagues, the selection of patients for oestrogen assays was made by our obstetricians and the criteria for selection were the usual criteria which are used throughout the country for the identification of high-risk patients. The lack of a significant difference in the number of fetal deaths between those who had their pregnancies monitored by oestrogen assays and those who did not would make it appear that the selection of patients for this assay is ineffective. This conclusion is not strictly true, because many of the fetal deaths occurred in patients who did not receive any antenatal care, including oestrogen assays. Most of these patients were from a poor socioeconomic background, had failed to attend any of the antenatal clinics, and came to hospital in labour. To that extent the results are biased.

There is also a category of patients who had fetal deaths without any clinical signs of high risk, and this category has been termed "cause unknown" in the classification by clinical cause of perinatal deaths used in Glasgow.¹ Your leading article (15 January, p 123) on the prediction of fetal death has stressed the difficulties of the obstetricians and is worth quoting: "The obstetrician's second patient (who is the one most at risk) is buried in the maternal tissue, so that the predicament is like that of a physician asked to assess a patient in full winter dress and refusing to take off even the greatcoat. In consequence obstetricians are relying more and more on scientific techniques to give them insight about the hidden fetus." Therefore I feel that every patient must be monitored at least thrice weekly, if not daily. I know that it will be a considerable effort for the laboratory, but I do not see any real alternative at the present time.

L G S RAO

Biochemistry Department,
Maternity Hospital,
Bellshill, Lanarkshire

¹ McNay, M B, *et al*, *British Medical Journal*, 1977, **1**, 347.

The perilous skateboard

SIR,—Your correspondent Dr A R Rogers (15 October, p 1026) seems to be displaying in his attitude towards skateboards the kind of holier than thou elitism that is so common in the medical profession. The research to date refutes his impression. Certainly my series of 70 suggests that the majority of injuries are relatively minor—Colles's fractures and sprained wrists contribute about 70% of all accidents, and we have had no serious head injuries. Only three children required admission and they were overnight stays only. It is true that according to the press¹ 13 people

have died as a result of skateboarding in America, but how many million skateboards are in use over there?

My impression, for what it is worth, is that skateboarding is a lot safer than rugby or boxing, and infinitely safer than travelling in a car or on a motorcycle. Skateboards are like cars: they are not dangerous, but the people who use them may be. Why must doctors always be seen to be promoting the negative rather than the positive in people's lives? We live in a culture of isolation and boredom; we should be trying to do something about that before we condemn activities out of hand without the information necessary to back it up.

S GLASCOE

Royal Gwent Hospital,
Newport, Gwent

¹ *Daily Telegraph*, 1 September 1977.

Switching off

SIR,—I write to protest against the practice of asking relatives for permission to disconnect life support systems in cases where brain death has been diagnosed. This is both illogical and cruel and in many cases may prove to be counterproductive.

It is illogical because the relatives are not involved in the decision to put the patient on life support. Nor indeed could they be. The decision to initiate life support is a medical one and by the same token the decision to disconnect is a medical one. Fortunately, we now have clear guidelines on the diagnosis of brain death, which are contained in the statement issued by the honorary secretary of the Conference of Medical Royal Colleges and their Faculties in the United Kingdom on 11 October 1976.¹

It is cruel because relatives are placed in an agonising dilemma by being asked to agree to the switching off. They do not have the medical knowledge to make a scientific judgment so they are, in effect, being asked to make a moral judgment. But in asking for a moral judgment at such a time we are placing them on the horns of a dilemma. If they say yes, they may feel they are taking a life. If they say no, they may feel they are unnecessarily prolonging death or indefinitely prolonging a useless life. Without full medical knowledge they cannot give a reasoned answer and whichever answer they give they will be left with doubts. What the relatives need is support in their distress and confidence in the judgment of their medical advisers. Our duty is to make up our minds and then quietly and sympathetically inform the relatives that life support will be withdrawn because we have determined by a battery of tests that the brain is dead.

Asking the relatives for permission to switch off is likely to be counterproductive both to the patient and to others. If permission is refused and a useless life is prolonged then an intolerable burden will be placed on the relatives. Moreover, the unnecessary postponement in switching off may result in such physical deterioration of the patient that his kidneys can no longer be used to save another life.

In conclusion, I would like to emphasise that I am not suggesting that the relatives should not be involved in the decision to withdraw life support. I am suggesting that they should not be asked to make the decision. We as a medical profession should have the

courage of our convictions and recognise that it is our responsibility to make the decision on the medical evidence.

A W FOWLER

Bridgend General Hospital,
Glamorgan

¹ *British Medical Journal*, 1976, 2, 1187.

The neonatal electrocardiogram and unexpected death in infancy

SIR,—We do not agree with the negative opinion expressed by Professor J L Emery (24 September, p 833) on the value of a major ECG screening study to investigate the possible relationship between cardiac arrhythmias and unexpected infant deaths. The population in Sheffield was selected and relatively small. Furthermore, no information was given on the type of ECG or the duration of the rhythm strips carried out.

We have demonstrated, using 24-hour monitoring, that some infants with normal screening ECGs have serious cardiac arrhythmias. We still consider a prospective multi-centre study essential to determine whether cardiac arrhythmias occur regularly in infants throughout the country, whether they are dangerous, and finally whether they can cause sudden death.

D P SOUTHALL
E A SHINEBOURNE

Brompton Hospital,
London SW3

Oxytocin and neonatal jaundice

SIR,—Several UK centres have reported a recent increase in neonatal jaundice.^{1,2} Oxytocin or some as yet unidentified obstetric practice has been held responsible.^{3,4} However, there is some doubt that a genuine increase in the incidence of neonatal jaundice has occurred since serial figures^{1,5} are few and the incidence of jaundice increases with the proportion of neonates whose plasma bilirubin is measured. We have sent questionnaires to paediatricians in Europe (E) and North America (A) asking their recent experience of jaundice rates.

Sixty-six members of the European Society for Paediatric Research were circularised; 52 replied. A random 1 in 5 sample of the American Pediatric Society, total 135, were also circularised; 100 replied. Thirty-nine of the Europeans and 51 of the North Americans were in active practice in neonatology. The majority, 66% (E) and 60% (A), thought there had been no increase in neonatal jaundice since 1970. Only 23% (E) and 24% (A) thought jaundice had increased. The remainder were uncertain. The respondents' estimate of the present percentage of neonates having a peak plasma bilirubin concentration of 206 $\mu\text{mol/l}$ (12 mg/100 ml) or greater in the first 7 days after birth varied between 2 and 30%. The averages of all the replies, 14.2% (E) and 12.6% (A), were similar to the published incidence in unselected series.⁵ We asked also about the use of phenobarbitone in late pregnancy for the prophylaxis of neonatal jaundice. Only 13% (E) and 8% (A) paediatricians used this occasionally; none used it routinely.

If oxytocin were icterogenic then we would have expected most paediatricians in North America and Europe to have noticed some

increase in neonatal jaundice. The fact that they have not casts further doubt on this association.

LOUISE FRIEDMAN
PETER LEWIS
DAVID HARVEY

Institute of Obstetrics and
Gynaecology,
London

¹ Campbell, N, *et al*, *British Medical Journal*, 1975, 2, 548.

² Sims, D G, and Neligan, G A, *British Journal of Obstetrics and Gynaecology*, 1975, 82, 863.

³ Beazley, J M, and Alderman, B, *British Journal of Obstetrics and Gynaecology*, 1975, 82, 265.

⁴ Chew, W C, and Swann, I L, *British Medical Journal*, 1977, 1, 72.

⁵ Lewis, P J, *Therapeutic Problems in Pregnancy*, p 141. Lancaster, Medical and Technical Publishing, 1977.

Sealing of wounds with vacuum drainage

SIR,—Most surgeons these days make use of vacuum drainage with zimmer bottles or similar apparatus and many surgeons no doubt have learnt the value of sealing these wounds and the emergent drainage or drains with such adhesive films as Opsite or Steri-drapes. These substances are, however, expensive and I have found that simple household Cling, so useful in the kitchen, makes a most satisfactory substitute.

In view of the lack of sterility, it is best to cover the wound and emergent drain or drains with a small strip of gauze or ribbon gauze. The whole area is then generously sprayed with Onibuctane and the film of Cling spread over. This technique is of especial help when a vacuum tube has to be replaced from without in through a new stab wound. The Cling gives rise to a new and most effective vacuum seal.

C PATRICK SAMES

Bath

Raised plasma urea concentration

SIR,—Surprise was expressed by Professor D B Morgan and others (8 October, p 929) on finding heart failure to be the commonest cause of a raised plasma urea in a general hospital. In a study which I undertook on subjects suffering from acute myocardial infarction, 50% had abnormally high plasma urea concentrations and 41% had high creatinine concentrations at some time during their stay in hospital.¹ Since such cases constitute a substantial proportion of hospital admissions, the observation made by these workers is perhaps not so surprising after all, and presumably their congestive heart failure group would include subjects of this type.

Urine estimations on a small number of patients in my investigation indicated that while glomerular filtration was sometimes decreased, as judged by creatinine clearance, urea excretion over 24 hours tended to be normal or high. Although the two studies are not strictly comparable, being designed for different purposes, some similarities do exist. For example, in both cases mortality was associated with the highest levels of plasma urea, and my results suggested that daily plasma urea measurement might be helpful in monitoring progress and prognosis in acute myocardial infarction.²

Professor Morgan and his associates list decreased glomerular filtration rate as one of three general causes of a raised plasma urea, and in heart failure this may result from poor renal perfusion. Hence the uraemia occurring in this condition seems likely to have poor circulation as its primary cause, but with a mixed secondary aetiology of tissue breakdown due to stagnant tissue